PUBLIC HEALTH COUNCIL

A regular meeting of the Massachusetts Department of Public Health's Pub lic Health Council was held on Wednesday, July 11, 2007, 10:15 a.m., at the Department of Public Health, 250 Washington St., Boston, Massachusetts in the Henry I. Bowditch Public Health Council Room. Members present were: Chair John Auerbach, Commissioner, Department of Public Health, Ms. Helen R. Caulton-Harris, Mr. Harold Cox, Dr. Michèle David, Mr. Paul J. Lanzikos, Dr. Philip C. Nasca, Ms. Lucilia Prates Ram os, Mr. José Rafael Rivera, Mr. Albert Sherman arrived at approximately 10:35 a.m., Dr. Michael Wong, and Dr. Alan C. Woodward. Absent Members were Dr. Muriel Gillick and Dr. Barry S. Zuckerman. Also in attendance was Attorney Donna Levin, General Counse l, Department of Public Health.

Chairperson Auerbach announced that notices of the meeting had been filed with the Secretary of the Commonwealth and the Executive Office of Administration and Finance .

RECORD OF THE PUBLIC HEALTH COUNCIL MEETING OF MAY 24 , 2007:

A record of the Public Health Council Meeting of May 24, 2007 was presented to the Council for approval. A copy of minutes was distributed to the Council Members prior to the meeting for review. Council Member Cox moved for approval. After cons ideration, upon motion made and duly seconded it was voted unanimously [Council Member Sherman not present to vote] to approve the Record of the Public Health Council Meeting of May 24, 2007 as presented.

REGULATION: REQUEST FOR ~~EMERGENCY APPROVAL*~~ OF PROPOSED AMENDMENTS TO HOSPITAL LICENSURE REGULATIONS 105 CMR 130.1200 AND 130.1300 ET SEQ.: TO REQUIRE HOSPITALS ASSUMPTION OF THE COSTS OF CARDIAC DATA COLLECTION:

*NOT APPROVED AS PRESENTED – SEE BELOW

Dr. Paul Dreyer, Director, Bureau of Health Quality Assurance and Control, presented the request for emergency approval of the proposed amendments to 105 CMR 130.000. to the Council.

Mr. John Auerbach, Chair opened the discussion. He said, "The Council Members would like to hear why this particular regulation is considered an 'emergency' instead of going through the normal regulatory process?"

Dr. Dreyer responded that he would address that question during his presentation to the Council. He gave an overview of the Department's Cardiac Data Re porting System. During his presentation he noted the following:

- The proposed amendments would require each hospital in the Commonwealth that provides cardiac surgery and angioplasty services to pay for the cost of required data analysis for those programs.

- The collection of the data was mandated by an outside section of the FY 2001 state budget and funded by a separate line item in the state budget. After two years of such funding the line item was eliminated requiring the Department to support the program without a specific appropriation for that purpose.

- The Department of Public Health promulgated amendments 105 CMR 130.000 to require the collection of the requisite data sets in 2002, and awarded a contract to the Harvard Medical School ("MassDac") to manage the data collection and analysis at that time.

- Hospitals began collecting and reporting data to MassDac in 2003.

- The Department has produced reports on the quality of surgical and angioplasty programs since 2005, and produced the state's first report comparing the performance of individual cardiac surgeons in 2006.

Dr. Dreyer stated, "That the Department convened a sub-committee of representatives from hospitals with surgical and interventional cardiology programs to develop an approach to fairly allocate the costs of the program to each of the participating hospitals based on the volume of services they provide…The proposed amendments require hospitals to participate in ongoing funding of the data collection effort, in accordance with details to be set forth in an advisory bulletin. The advisory bulletin will specify the allocation methodology as negotiated with the hospitals. It will require each hospital that performs either angioplasty or open heart surgery to pay to MassDac a fixed fee of $10,000, and an additional allocation based upon the proportion of total angioplasty and open heart surgery procedures in Massachusetts that it provides. The total cost of the program has historically been under $500,000, so under the planned allocation strategy, no single hospital would be required to pay over $75,000."

For the record, Council Member Sherman arrived during Council discussion on these proposed amendments to 105 CMR 130.000.

Per the Chair's request, Dr. Dreyer explained the procedure for promulgation of regulations. That is with 'emergency' regulations they become effective immediately after the Council approves them and are filed with the Secretary of the Commonwealth and remain in effect for 90 days. The Department must hold a public hearing in compliance with M.G.L. c.30A. Following the hearing, staff will return to the Council with a summary of all comments received and their responses to those comments, and any proposed revisions. Following the Council's approval, the Department must then finalize the amendments with the Secretary of the Commonwealth before expiration of the 90-day period. The normal route for

proposed regulations (not emergency) would be to have staff present information on proposed regulations to the Council (no vote). The Department would hold the public hearing/comment period first and then bring the proposed regulations to the Council for a vote. The regulations would become effective upon their publication in the Massachusetts register.

Dr. Dreyer noted further, "The Department requests emergency approval so that hospitals may immediately begin to plan for inclusion of the costs in their budgets and further so the hospitals would start paying October 1, 2007."

A discussion followed by the Council on the need for the emergency promulgation versus the normal regulatory procedure. See the verbatim transcript for full discussion.

Dr. Dreyer noted that the Massachusetts Hospital Association (MHA) and hospitals are in agreement with the proposed regulations. Council Member Helen Caulton-Harris questioned, "Why an emergency if you have general consensus and the hospitals are going to be compliant because you had these discussions? Why do we need to put them on notice in an emergency regulation?" Dr. Dreyer responded, "If no mandate one or two things could happen – those who voluntarily pay and those who don't. It wouldn't be an equitable situation. I think it is important that all hospitals participate." Dr. Alan Woodward, Council Member also asked, "If you hear zero opposition to this. All hospitals and MHA are behind it – total consensus. It would seem without emergency regulations they would continue it. Does this rise to the level that we should abbreviate our process or should we go to public hearing, and after 90 days, the regulations will still go into effect around October 1st. Harold Cox, Council Member added, "…I don't hear any disagreement about the proposed regulations. It is the nature of the 'emergency' piece that is being questioned. You said reason to do now is to put the hospitals on notice. They already agreed and are interested in doing it. That's not feeling strong enough for me. Can you state the case why emergency action should be taken?"

Dr. Dreyer responded, "The Department needs to say that this is the way it is going to be and bring this process that we have been working on to a conclusion. The cleanest way to do that is with an emergency regulation." Council Member Cox asked further, "Can you tell me the downside of not taking action today?" Dr. Dreyer stated, "It leaves us in limbo for some period of time whether or not the Department is ultimately going to say the development process is done and now is the time to begin. It essentially delays the mandate. I think from our point of view and the hospitals the sooner we can end any ambiguity of whether this is a mandate the better off we will be." Discussion continued and Mr. Cox said, "I think what the Council is saying or at least what you hear me saying, is that we want to make certain that we give the hospitals the opportunity to respond to this and to be able to weigh that information as we, as a body, make a decision." Dr Michèle David asked if the funding for this is through hospitals fees in other States and Dr. Dreyer replied that in most states, the funding is from legislative appropriation like it was originally in Massachusetts.

Three action steps that the Council could take were discussed:

1. Vote emergency approval of the proposed regulations.

2. No vote by Council but have the regulations proceed in the standard, regulatory process of going to public hearing and comment period.

3. Council vote and endorse general language/concept of the proposed regulations and have regulations proceed through normal regulatory process.

Discussion continued, Dr. Alan Woodward asked that the regulations follow the normal process but called for an expedited process – perhaps bringing the regulations back to the Council in September. Council Member Dr. Philip Nasca made the motion, stating, "I would like to make a motion that would endorse Dr. Woodward's approach. I think that makes sense. The Council seems somewhat uncomfortable with the word 'emergency' in this case. So, the alternative would be to put these regulations back into the regular process but with an expedited review, I think that makes a lot of sense, and I would endorse that."

Attorney Donna Levin, General Counsel, Department of public health clarified for the record that the regulations will follow the required Chapter 30A public hearing process – the expedited process refers to abbreviating the staff review time not the public hearing process.

Council Member Helen Caulton-Harris noted, "I guess it is important from what we said just to reiterate an 'emergency' for this Council needs to rise to urgency, not an emergency but an 'urgency' to be considered emergency regulations. It was critical that we were able to have this discussion…" Dr. Woodward added, "I would like to commend staff for achieving consensus on this…I understand all the work that it must of taken to get there…It sounds like hospitals and MHA recognize the value of this. My only concern is if any opposition that it be incorporated in the record…"

After consideration, upon motion made and duly seconded, it was voted unanimously to endorse the concept of the proposed regulations **(Proposed Amendments to Hospital Licensure Regulations 105 CMR 130.1200 and 130.1300 et seq. to acquire hospitals to assume the costs of cardiac data collection)** and further that the regulations should proceed to public hearing first [rather than being approved as emergency regulations] and that following the public hearing and review of the comments, staff should return the regulations expeditiously as possible (hopefully in September) for final action/vote of the Council.

Dr. Dreyer stated, "This will work out perfectly well."

PRESENTATIONS:

"CANCER INCIDENCE AND MORTALITY IN MASSACHUSETTS, 2000 -2004", By Susan Gershman, Director, Massachusetts Cancer Registry Program

"STATEWIDE DATA REPORT ON THYROID CANCER IN MASSACHUSETTS", By Richard Knowlton, Epidemiologist, Massachusetts Cancer Registry Program

GUEST SPEAKERS:

Dr. Erik K. Alexander, Endocrinologist and Associate Physician, Brigham & Women's Hospital

Janet McGrail Spillane, Vice President, American Cancer Society

Dr. Susan Gershman presented the statewide report on cancer incidence and mortality in Massachusetts for 2000 to 2004. Dr. Gershman noted in part, "…This report provides statewide information on cancer incidence and mortality in Massachusetts for 24 types of cancer and for all cancers combined for 2000 through 2004; provides detailed information about the most commonly occurring types of cancer for 2000 through 2004; examines cancer incidence patterns by age, sex, and race/ethnicity; reviews Massachusetts cancer incidence and mortality trends for 2000 through 2004; compares Massachusetts incidence and mortality data with national incidence and mortality data; and provides detailed information about bladder cancer in Massachusetts…This year, the special section focuses on bladder cancer and includes 23 year incidence and mortality trends and age-conditional probabilities of developing and dying from bladder cancer…"

Dr. Gershman noted that this year's report could not be compared to past reports due to a major change in the population data in this report. Starting with this report, new population estimates are being used for the period 2000 -2004. The population estimates are from the Census Bureau's Population Estimation Program. This is because the overall population count and the age distribution of the population, which were based on the Census 2000 count, differ. The difference in the new population estimates is pronounced for Hispanics and black non-Hispanics. Refer to Appendix II of this report for more detail.

Some highlights from the report follow:

- From 2000 to 2004 there were 174,719 newly diagnosed cases of cancer and 68,485 deaths from cancer among Massachusetts residents. The average annual age-adjusted incidence rate was 515.4 per 100,000 persons, and the average annual age-adjusted mortality rate was 197.0 per 100,000 persons.

Overall, cancer incidence rates for males in Massachusetts over the years 2000-2004 decreased an average of 1.6% per year, though this decrease was not statistically significant. Among Massachusetts females, overall incidence rates remained stable over this time period. Mortality from all types of cancer combined decreased by 2.9% annually for males, and by 1. 7% for females from 2000-2004, both statistically significant decreases.

- Prostate cancer was the most common type of newly diagnosed cancer among Massachusetts males. Prostate cancer accounted for 29% of new cancers among males in the state from 2000 to 2004. The average annual age-adjusted incidence rate of prostate cancer was 176.1 per 100,000 males. The annual incidence rate of prostate cancer decreased an average of 5.5% per year, a statistically significant trend from 2000 to 2004. The mortality rate of prostate cancer decreased significantly by 6.4% per year from 2000 to 2004.

- From 2000 to 2004, invasive breast cancer was the most common type of newly diagnosed cancer among Massachusetts females, accounting for approximately 29% of new cancers among females in the state. The average annual age-adjusted incidence rate of breast cancer was 136.7 per 100,000 females. The incidence rate of female invasive breast cancer decreased significantly over the years 2000-2004 by 2.1% annually. The mortality rate from breast cancer also decreased during this period by 3.0% annually, which was statistically significant. The age-adjusted incidence rate of in situ (early stage diagnosis) breast cancer for Massachusetts females was 47.5 per 100,000.

- Cancer of the bronchus and lung was the most common cause of cancer deaths among both Massachusetts males and females between 2000 and 2004, accounting for 29% of all deaths among males and about 25% of all deaths among females. During this time period, the mortality rate of cancer of the bronchus and lung in Massachusetts decreased by 2.6% annually for males and decreased by 0.2% annually for females. These changes were statistically significant for males, but were not significant for females. The slight decrease for females, however, is encouraging given that for the period of 1999-2003, female mortality rates due to lung cancer had increased significantly by 2.7%.

- The incidence rate of cancer of the bronchus and lung increased by 0.6% per year for Massachusetts females during 2000-2004 and decreased by 1.7% for males. Neither of these changes was statistically significant.

- For all types of cancer combined for 2000-2004, black, non-Hispanics had the highest age-adjusted incidence and mortality rates among Massachusetts males. Both the incidence and the mortality rates were significantly higher than all other racial/ethnic groups.

- For all Massachusetts male race/ethnicity groups diagnosed between 2000 and 2004, cancers of the prostate, bronchus and lung, and co lon/rectum were the top three most commonly diagnosed cancers, and cancer of the bronchus and lung was the most common cause of cancer death.

- For all types of cancer combined for 2000-2004, white, non-Hispanics had the highest age-adjusted incidence rate among Massachusetts females and black, non-Hispanic females had the highest age-adjusted mortality rates. While the mortality rates for black, non-Hispanic females were significantly higher than those of Asian, non-Hispanic females and Hispanic females, they were not statistically significantly different from those of white, non-Hispanic females.

- Breast cancer was the most commonly diagnosed cancer for all Massachusetts female race/ethnicity groups from 2000 to 2004. Cancers of the bronchus and lung and colon/rectum were among the next two leading cancers among females. Bronchus and lung was second and colon/rectum were among the next two leading cancers among females. Bronchus and lung was second and colon/rectum was third for white, non-Hispanic and black, non-Hispanic females. For Asian, non-Hispanic and Hispanic females, colon/rectum was second and bronchus and lung was third.

- Between 2000 and 2004, cancer of the bronchus and lung was the most common cause of cancer death among all female race/ethn icities in Massachusetts, except for Hispanic females. Breast cancer was the most common cause of death among Hispanic females.

- Age-adjusted cancer incidence rates in Massachusetts were generally higher than their national counterparts. The Massachuset ts male and female incidence rates for all sites combined for the period 2000 through 2004 were 604.8 per 100,000 and 455.5 per 100,000, respectively, while the 2000-2004 rates for the North American Association of Central Cancer Registries (NAACCR) were 557.8 per 100,000 and 413.1 per 100,000, respectively.

- Similarly, age-adjusted cancer mortality rates in Massachusetts females for 2000-2004 were slightly higher than age-adjusted mortality rates in the United States, and male mortality rates were slightly lower. For all cancer sites combined, national versus Massachusetts mortality rates were 243.7 per 100,000 versus 241.6 per 100,000 for males and 164.3 per 100,000 versus 169.2 per 100,000 for females.

- Urinary bladder cancer incidence and mortality rate s have remained rather stable over the last decade with males having higher rates than females. Over the last five years, the probability of developing urinary bladder cancer over a lifespan (0-85 years) was 3.5% for males and 1.2% for females, but the probability of dying from urinary bladder cancer was only 0.7% for males and

0.3% for females.

Mr. Richard Knowlton, Epidemiologist, Massachusetts Cancer Registry Program, presented the Statewide Data Report on Thyroid Cancer in Massachusetts.

Mr. Knowlton explained where to locate the thyroid gland. He said, "The thyroid gland is located in the middle of the neck below the larynx (voice box) and just above the clavicles (collarbones). It is shaped like a bow tie, having two halves (lobes) joined by an isthmus. It is an endocrine gland, whose follicular cells make thyroid hormones to regulate physiological functions in the body such as heart rate, body temperature, and energy level. Its parafollicular or C cells make calcitonin, a regulator of the body 's calcium metabolism.

There are four types of thyroid cancer: Papillary cancer, the most common, accounting for 70% of thyroid cancers. The next most common type is Follicular cancer which accounts for 15% of thyroid cancers. Medullary cancer of the t hyroid accounts for about 5-8% of thyroid cancers. Anaplastic cancers of the thyroid are the least common 0.5 to 1.5% and the most deadly of all thyroid cancers.

He said in part, "…Mortality from thyroid cancer, it is very low, with the exception of the Anaplastic form…From 1999 to 2003, morality rates for males and females were 0.4 and 0.5 per one hundred thousand and this makes it one of the cancers with the lowest mortality rate, and this is reflected in National rates as well."

Mr. Knowlton explained, "The reason for the increases in thyroid cancer tumors 1cm and less appear to be the result of better detection with fine needle aspiration biopsy and ultrasound. The increase in the larger tumors between 1.1 and 5 cm suggests better clinician awareness of thyroid cancer as well as an increase in neck palpations as part of a routine medical examination. The greater increase of papillary cases in females, the larger mean size of tumors in males, and the later stage at diagnosis in males from 2001 to 2003 indicate detection among females who may be utilizing the health care system more than males. As the Massachusetts Cancer Registry is a surveillance database, there is no information on radiation exposure, diet or hormonal factors that could be relate d to thyroid cancer cases."

Statistics from the report follow:

- Thyroid cancer incidence rates for males and females combined in Massachusetts increased significantly between 1984 and 2003, from 3.4/100,000 in 1984 to 12.7/100,000 in 2003

- From 1995 to 2003, incidence rates among males increased by 66%, from 3.8% to 6.3/100,000. Rates among females increased by 81%, from 10.7 to 18.7/100,000. The ratio of female to male cases was 3:1 during this period. This is consistent among the four major racial/et hnic groups.

- From 1999-2003, thyroid cancer incidence rates were elevated for Asians in Massachusetts, which mirrors trends in other parts of the United States. The numbers for specific Asian ethnicities in Massachusetts were too small for a meaningful analysis.

- From 1984 to 2003, 95% of the increase in thyroid cancer has been attributable to increases in the papillary form of the cancer.

- The incidence rate of papillary thyroid cancer has increased significantly since 1997, with an annual percentage increase of 14.3%.

- Among papillary thyroid cancer cases from 1995 to 2003, tumors less than 5 cm increased significantly compared to those larger than 5 cm. The tumors 1 cm or less, the papillary thyroid microcarcinomas, accounted for 41% of the increase, those 1.1-2.0 cm accounted for 30%, and those 2.1 to 5.0 cm accounted for 26%.

- The mean size of papillary tumors has been larger for males compared with females for the years 1995 to 2003. During this period, the mean tumor sizes at diagnosis dropped from 2.5 cm to 1.7 cm for females, and 2.6 cm to 2.1 cm for males.

- From 2001 to 2003, females were significantly more likely to be diagnosed at the local stage than males. Males were significantly more likely to be diagnosed at the regional stage than female, and both sexes were equally likely to be diagnosed at the distant stage.

- From 1999-2003, mortality rates were approximately 0.5/100,000 for both sexes, a rate comparable to the national rate.

Dr. Erik K. Alexander, Endocrinologist and Associate Physician, Brigham and Women's Hospital addressed the Council: He said in part, "…I think it is important to emphasize that this mirrors a national issue. It is not alone to Massachusetts, and is something that has certainly hit the prime time, if you will, with endocrinologist and probably physicians as a whole because there is a dramatically increasing incidence of cancer, where most other malignancies are decreasing, and I think it begs two questions; which is, first, can we explain why this is, and the second, more broader issue, is it going to prompt any sort of intervention that should change policy to improve health, or to try and figure out why this is."

Dr. Alexander continued, "I think the first question, can we explain it, the answer probably being…First and foremost, we are using ultrasound a lot more in terms of imaging the thyroid, which is a very sensitive means of imaging, and has been able to detect a more sensitive, and a smaller lesion than ever had been seen before. This intervention came about in the mid-1990s. That turning point of around 1995 to 1997

really is telling and, again, the parallel as to how much more ultrasound is being used in the detection, monitoring, evaluation of patient with thyroid nodules is almost too coincidental to think that it is not a major factor as to why we are seeing more."

Dr. Alexander said further, "I think second to actually finding more is the issue that perhaps there is a slight change in terms of how pathologists who interpret whether a lesion is benign or cancerous are interpreting their data. Whereas before, we used to have quite a bit of follicular adenomas, which are considered benign thyroid lesion, there has been a shift in the last two decades to also realizing that nuclear changes in the structure of the cell actually implies that there perhaps are, that some of these so-called follicular adenomas actually are now considered papillary carcinomas. That is a shift from a benign to a malignant condition on paper, and it has really, I think been a secondary increase."

"Perhaps the third," he said, "and the major driver was the size of these papillary carcinomas, and what contributes to the increased incidence, at least half are small lesions, under one centimeter. It is now quite widely believed, albeit that these data are based off of retrospective analyses, that is all we have in the field, given the long term issue with thyroid cancer, it is not a uniformly lethal, imminent disease most of the time. When you look at the data, it is quite clear that there is a difference between a thyroid cancer that is one centimeter or greater, and thyroid cancer that is less than one centimeter, in terms of its behavior, its risk, and therefore that has driven a recommendation, now via both American and National agencies, and European, as well, to biopsy or evaluate nodules only once they are over one centimeter in size, and some would argue one and one half centimeters. I bring that up because the majority of what is driving this, 50%, are lesions less than one centimeter and it is quite likely that some of that, albeit you cannot determine this conclusively from the data we have, much of this is being driven by people having thyroidectomies for otherwise nodules over one or two centimeters that likely were benign. However, it is very common to find a separate, so-called micropapillary carcinoma, as an incidental bystander that measures two, three, or four millimeters. If that is coded as a malignancy, albeit that is not what brought the patient to surgery that they subsequently had, that will drive statistics to be higher than you might normally expect."

In closing, Dr. Alexander stated, "While I think the data are very important and deserve further watching, I also think that it is worth stepping back and not perhaps, being quite so alarmed that there is any clear evidence of a environmental driver to this increased incidence."

Ms. Janet McGrail Spillane, Vice President, American Cancer Society, and Co-Chair of the Massachusetts Comprehensive Cancer Coalition (the other Co-Chair is Dr. Cynthia Boddie Willis):

Note: For the record, Council Member Harold Cox left the meeting at 11:45 a.m. during Ms. McGrail's presentation.

Ms. McGrail Spillane said, "I was asked to give a brief overview of the American Cancer Society and their efforts in prevention and early detection. I am going to give some perspectives of what we are doing with the coalition. The American Cancer Society efforts are really through these areas - through advocacy and education. We work with hospitals and health centers, providers, employers, health departments through the service of the Massachusetts Comprehensive Cancer Coalition. We have a call center (1-800-ACS-2345, which is available 24/7…We also have an extensive data-base on where to find resources and assistance if you are diagnosed with any kind of cancer. We also have a web page, www.cancer.org. We fund 38 million dollars worth of cancer research in the state of Massachusetts…"

In closing, she noted in part, "I just wanted to highlight that the Department of Public Health has a very active Tobacco Department, Women's Health Network, Colorectal Department and Prostate. The Massachusetts Comprehensive Cancer Coalition also has a work group. The two tend to mirror each other and complement one another, rather than being redundant and repeat the work that is done. The American Cancer Society has active members on all the work groups, and we have a very active working relationship with the Department of Public Health around all those things, and we are the advocacy arm that tries to help all the groups that are working in those fields, and to be kind of the mouthpiece, or the lobbyist at the State House and in Washington..."

To highlight some of the activities the American Cancer Society and/or Coalition are involved in:

- Advocacy: Lobby on national, state and local levels
- Education
- 24/7 hot line for cancer information and services (60,000 calls a month)
- Maintain as web page www.cancer.org
- Cancer Research
- Cancer Resource Network
- Volunteer drivers
- Peer-to-peer education to get women through breast cancer
- Free wigs, booklets and information
- Long history of working with DPH's "Women's Health Network", breast and cervical cancer programs
- Dispense community grants across the state
- Working on a breast cancer conference together with the Komen Foundation, Avon and DPH (to be held on November 5)
- Support Mobile Mammography Van (Van owned by City of Boston and run by Dana Farber Cancer Institute)
- Promote October Breast Cancer Awareness Month
- Work with hospitals in the Breast Cancer Paint the Town Pink campaign
- Media campaigns in October and May
- American Cancer Society's Great American Smoke out campaign

- Work with schools to bring awareness to young children about the dangers of smoking
- House the Tobacco-Free Mass Coalition
- Since 1997 have had an active Colorectal Working Group
- The comprehensive Cancer Coalition receives CDC funding and has a state five-year plan
- The Coalition is a member driven organization, powered by volunteers with a leadership team and five working groups (recent regional membership drive – now up to 400 members)
- Coalition has electronic newsletter

Discussion followed by the Council. Dr. Alan Woodward, Council Member, noted, "Lung and bronchus cancer is the number one killer and it's also totally preventable. It was basically unknown prior to smoking and, as you know, or I suspect you have all seen Howard Koh's article this morning in the Boston Globe Newspaper, editorial, and even when we look at the current budget, it is still a third of the four that is recommended by the CDC, and we were winning this battle. We reduced the smoking rate by 50%, roughly, and now it is rising again. So, looking forward, we obviously anticipate an increase of the preventable disease. I think it would be useful for us all to work on the budgetary constraints that have been put on this tremendously successful program, recognizing that between taxes on cigarettes and the tobacco settlement, six hundred million dollars coming into the coffers of this State, and there was a total evisceration of the program in 2002, with a 95% cut and now it is going to be twelve million of that six hundred million that is spent on this; and, as you know that this is an incredibly effective prevention program. It is probably the most successful immunization we have from a public health perspective. Hopefully, we can again gain momentum on dealing with this, using your data, hopefully, to reinforce the efforts in this effort because this is clearly an area where we need to redouble our efforts. It has been proven effective and cost effective, and yet has been cut to the extent it has, and we also know and it is nice to see that, in the Medicaid program, there is funding for this. So we know that this is an increasing problem within the indigent populations that have less access to health care."

Dr. Michele David, Council Member said, "I echo what Dr. Woodward said, in terms of lung cancer because what I found. I treat women. I am a Women's Health Specialist, Internist. Everybody is scared about breast cancer, and we don't really have a public campaign that says lung cancer is what kills you. Even though the incidence of breast cancer is higher, lung cancer is what kills women, as well as men, and so, in addition to all the tobacco cessation programs, we really need a public campaign so that people know that lung cancer is killing them a lot more than breast cancer would, so that people know that as currently as they know that they need a mammogram for the breast cancer prevention."

Chair Auerbach added, "…While funding is not where it was at its height, we are likely to receive, with the legislature's final vote to receive an increase in our tobacco control funding for DPH of about four and a half million dollars and that will allow us to restore

some of the programs that were historically funded at the Department, and it will also allow us to follow your guidance…"

Mr. José Rafael Rivera, Council Member added, "…I would like to advocate for the Gay, Lesbian, and Bisexual population, that may require a slightly different approach to prevention, but are definitely showing much higher rates of smoking, especially in the younger areas, than other groups." Chair Auerbach concurred.

Dr. Philip Nasca, Public Health Council Member stated, "…When we really think about cigarette smoking, it has probably had the largest impact on public health, the one single preventable thing, and we can extend it to coronary artery disease and emphysema and I could go on and on. If we really want to talk about limiting mortality in this country, from a wide variety of diseases, we have at hand the means to do it. While I applaud the Commissioner and the Legislature for appropriating more money for this, I think it is still totally inadequate, and I think that we could all do our part to push forward, to return to what I think is a reasonable level of funding. We are always worried about what causes this cancer and what we are doing in gene environmental interaction. We don't have to do this. This is classic public health. We know the cause of all this disease. We know how to prevent it, and we just need the political will to do it at this point."

Dr. Michael Wong, Council Member, said, "I would just like to add to that. I think there was some illusion, first, to prevention, using vaccines that potentially could prevent certain types of malignancies, as well. So, the combination of using a multi-fronted prevention effort really is fully advocated as best we can in this state, both with tobacco cessation programs or interventions to limit or stop tobacco use and smoking, but also advocating for vaccines, the Hepatitis B vaccines, those things wher e we can really make a big difference in those other areas." Dr. Wong further noted that he thought, "It would be very interesting to look at some of the demographics to see if part of the reason why the incidence and the mortalities are so disparate in s ome of these groups has to do with their lifestyle issue, tobacco use, environmental risk exposures, life cast, inability to actually access health care the way that we expect most people can."

Ms. Caulton-Harris, Council Member noted, "I want to, first of all thank all four of you. The presentation, especially the data is very enlightening, and the interpretation, and the American Cancer Society for really reaching across 495 and working within Massachusetts. It really has been a wonderful effort. I ju st want to add my voice to those who say that four million dollars is a wonderful increase in terms of the Legislature; but, from a Board of Health perspective, John, as you know, when you have workplace smoking ordinances, you have youth access ordinances in a town of 152,000 people, and you have 1.5 individuals to enforce those laws, I think we see from that preventative action, that the funding needs to be increased. If we are going to do good prevention and intervention, certainly, it is important that we are able to enforce the laws that we currently have on the books, and have the staff to do that, but thank the Board for highlighting the critical information for us."

Chair Auerbach added in part, "It sounds like the Council would appreciate a meeting in the future that perhaps focuses on the issue of tobacco control, and efforts that are being undertaken, that maybe highlight both the risk and the gap in terms of programmatic responses to that…Mr. Sherman was just commenting on the importance of high lighting the history of the program within Massachusetts, and the accomplishments that have been made over the years prior to the funding cuts."

Mr. Paul Lanzikos, Council Member, stated, " Relative to reaching out for screening, particularly mammography's and colorectal, and other broad-based screening programs, I was struck by, as I was looking through the booklet, I am struck by the fact that there is an absence of organizations that work regularly with people who are disabled, or elders who are homebound, who wouldn't get out to various public locations where fairs and other activities are concerned. I would offer to work with you and the Cancer Society to bring some of these other groups in. Roughly, we have about 300,000 people in the Commonwealth who are limited in terms of their ability to access a lot of the public programming, and yet they are at as much risk, maybe even more so, in terms of some of the issues that you have been presenting. I would be happy to sit down with you and see how you can broaden your Coalition a bit, but I commend you for what you have done so far."

Council Member Woodward, added, "I would just reiterate, I think this is great data, and it is really incumbent on all of us to kind of leverage that data, to have an impact on the public health. I would ask John, if it would be appropriate for the Public Health Council to commend the Legislature and the Governor for the 4.5 million dollars, but to point out that this is a third of what would be recommended by the CDC and a minuscule percentage of the six hundred million, and that we would strongly favor full funding of the minimum CDC guidelines so that we can really take this data and educate people that it is the number one killer, and it is 100% preventable."

Chair Auerbach replied, "I don't think that there is anything that prohibits the Council from expressing its opinion to the Legislature about a particular Public Health issue, so I do I hear a recommendation that we prepare such a letter on behalf of the Council…"

Council Member Alan Woodward, MD, made a motion that the Council should send an **official letter to the legislature, stating that funding sho uld be restored to the Tobacco Control Program (4.5 million dollar increase), the full funding as recommended by the Centers for Disease Control (CDC).** After consideration, upon motion made and duly seconded, it was voted unanimously to approve a letter being sent to the legislature requesting more funding for the Massachusetts Tobacco Control Program.

Discussion continued. Ms. Janet McGrail Spillane, ACS, noted that she just heard that at a legislative hearing being held that day, that the tobacco budget would be restored to35 million dollars." Council Member Woodward interjected, the letter would be in support of that concept, and what is reflected in Dr. Koh's article, in essence, and pointing out that this is a good, positive Public Health investment. This pays off in health care costs

down the line." Chair Auerbach noted that he would work with Kristin Golden, his Director of Policy and Planning and send the letter out to the legislature. It was suggested that the letter should be sent to the Senate President, House Speaker, Chairman of Ways and Means in both houses, and the Chairmen of both Health Care and Hea lth Care Finance Committees.

The meeting adjourned at 12:00 noon.

John Auerbach, Chair
Public Health Council

LMH/lmh